



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

NUEVA VIDA BEHAVIORAL HEALTH AND ASSOC.

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-15-0024-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

SEPTEMBER 2, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The appropriate CPT code for Health and Behavioral Intervention is 96152, which is accepted under the **Medical Fee Guideline for Worker's Compensation Specific Services.**"

Amount in Dispute: \$100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed a timed code 96152 for a behavioral health intervention. However, there is no start or end time on the document substantiating the 4 units (60 minutes) billed. No payment is due."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2014	CPT Code 96152 (X4) Health and Behavioral Intervention	\$100.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out medical fee guidelines disputed services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information..
 - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
 - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- 891-No additional payment after reconsideration.

Issues

Did the requestor support billing CPT code 96152 in accordance with 28 Texas Administrative Code §134.203? Is the requestor entitled to reimbursement?

Findings

The respondent denied reimbursement for CPT code 96152, based upon reason codes “CAC-16” and “225.”

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.”

CPT code 96152 is defined as “Health and behavior intervention, each 15 minutes, face-to-face; individual.”

A review of the submitted Treatment Progress Note does not document a start or end time to support the one hour billed. In addition, the requestor wrote “The patient was not able to come to his appointment but we spend an hour on the phone.” This phone conversation does not meet the definition of face-to-face; therefore, the Division finds that the requestor has not supported billing CPT code 96152.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	03/27/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.